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8 **BEFORE THE**  
9 **BOARD OF REGISTERED NURSING**  
10 **DEPARTMENT OF CONSUMER AFFAIRS**  
11 **STATE OF CALIFORNIA**

12 In the Matter of the Accusation Against:

Case No. *2013-916*

13 **MONICA LOUISE SALAZAR**  
5678 Hansen Drive  
Pleasanton, CA 94566

**A C C U S A T I O N**

14 **Registered Nurse License No. 470460**

15 Respondent.

16  
17 Complainant alleges:

18 **PARTIES**

19 1. Louise R. Bailey, M.Ed., RN (Complainant) brings this Accusation solely in her  
20 official capacity as the Executive Officer of the Board of Registered Nursing (Board),  
21 Department of Consumer Affairs.

22 2. On or about August 31, 1991, the Board issued Registered Nurse License Number  
23 470460 to Monica Louise Salazar (Respondent). The Registered Nurse License was in full force  
24 and effect at all times relevant to the charges brought herein and will expire on December 31,  
25 2014, unless renewed.

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## JURISDICTION

3. This Accusation is brought before the Board under the authority of the following laws. All section references are to the Business and Professions Code (Code) unless otherwise indicated.

4. Section 2764 of the Code provides, in pertinent part, that the expiration of a license shall not deprive the Board of jurisdiction to proceed with a disciplinary proceeding against the licensee or to render a decision imposing discipline on the license.

5. Section 118, subdivision (b), of the Code provides that the suspension, expiration, surrender, or cancellation of a license shall not deprive the Board of jurisdiction to proceed with a disciplinary action during the period within which the license may be renewed, restored, reissued, or reinstated.

## STATUTORY AND REGULATORY PROVISIONS

6. Section 2750 of the Code provides, in pertinent part, that the Board may discipline any licensee, including a licensee holding a temporary or an inactive license, for any reason provided in Article 3 (commencing with section 2750) of the Nursing Practice Act.

7. Section 2761 of the Code states in pertinent part:

"The board may take disciplinary action against a certified or licensed nurse or deny an application for a certificate or license for any of the following:

"(a) Unprofessional conduct, which includes, but is not limited to, the following:

"(1) Incompetence, or gross negligence in carrying out usual certified or licensed nursing functions.

..."

8. Section 2762 of the Code states in pertinent part:

"In addition to other acts constituting unprofessional conduct within the meaning of this chapter [the Nursing Practice Act], it is unprofessional conduct for a person licensed under this chapter to do any of the following:

"(a) Obtain or possess in violation of law, or prescribe, or except as directed by a licensed physician and surgeon, dentist, or podiatrist administer to himself or herself, or furnish or

1 administer to another, any controlled substance as defined in Division 10 (commencing with  
2 Section 11000) of the Health and Safety Code or any dangerous drug or dangerous device as  
3 defined in Section 4022.

4 ...”

5 9. California Code of Regulations, title 16, section 1442 states:

6 “As used in Section 2761 of the code, ‘gross negligence’ includes an extreme departure  
7 from the standard of care which, under similar circumstances, would have ordinarily been  
8 exercised by a competent registered nurse. Such an extreme departure means the repeated failure  
9 to provide nursing care as required or failure to provide care or to exercise ordinary precaution in  
10 a single situation which the nurse knew, or should have known, could have jeopardized the  
11 client’s health or life.”

12 10. California Code of Regulations, title 16, section 1443 states:

13 “As used in Section 2761 of the code, ‘incompetence’ means the lack of possession of or  
14 the failure to exercise that degree of learning, skill, care and experience ordinarily possessed and  
15 exercised by a competent registered nurse as described in Section 1443.5.”

16 11. California Code of Regulations, title 16, section 1443.5 states:

17 “A registered nurse shall be considered to be competent when he/she consistently  
18 demonstrates the ability to transfer scientific knowledge from social, biological and physical  
19 sciences in applying the nursing process, as follows:

20 “(1) Formulates a nursing diagnosis through observation of the client's physical condition  
21 and behavior, and through interpretation of information obtained from the client and others,  
22 including the health team.

23 “(2) Formulates a care plan, in collaboration with the client, which ensures that direct and  
24 indirect nursing care services provide for the client's safety, comfort, hygiene, and protection, and  
25 for disease prevention and restorative measures.

26 “(3) Performs skills essential to the kind of nursing action to be taken, explains the health  
27 treatment to the client and family and teaches the client and family how to care for the client's  
28 health needs.

1 “(4) Delegates tasks to subordinates based on the legal scopes of practice of the  
2 subordinates and on the preparation and capability needed in the tasks to be delegated, and  
3 effectively supervises nursing care being given by subordinates.

4 “(5) Evaluates the effectiveness of the care plan through observation of the client's physical  
5 condition and behavior, signs and symptoms of illness, and reactions to treatment and through  
6 communication with the client and health team members, and modifies the plan as needed.

7 “(6) Acts as the client's advocate, as circumstances require, by initiating action to improve  
8 health care or to change decisions or activities which are against the interests or wishes of the  
9 client, and by giving the client the opportunity to make informed decisions about health care  
10 before it is provided.”

#### 11 COSTS

12 12. Section 125.3 of the Code provides, in pertinent part, that the Board may request the  
13 administrative law judge to direct a licentiate found to have committed a violation or violations of  
14 the licensing act to pay a sum not to exceed the reasonable costs of the investigation and  
15 enforcement of the case, with failure of the licentiate to comply subjecting the license to not being  
16 renewed or reinstated. If a case settles, recovery of investigation and enforcement costs may be  
17 included in a stipulated settlement.

#### 18 FACTUAL BACKGROUND

19 13. In or around 2011, Respondent was employed as a registered nurse in the out-patient  
20 cancer center at Alta Bates Summit Medical Center in Berkeley, California.

21 14. Dilaudid® is a brand of hydromorphone hydrochloride, a Schedule II controlled  
22 substance as designated by Health and Safety Code section 11055(b) and a dangerous drug as  
23 designated by Business and Professions Code section 4022, used for pain relief.

24 15. In or around 2011, Respondent offered to assist VA<sup>1</sup>, a fellow nurse, dispose of two  
25 empty vials of Dilaudid. Respondent pretended to dispose of the vials in a bin. She then placed  
26 the vials in her pocket.

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27 <sup>1</sup> Initials are used herein to protect the nurse's privacy. The nurse's identity will be  
28 provided pursuant to a proper discovery request.

**Patient LL**

16. On or about April 8, 2011, Respondent provided care for Patient LL. At 4:02 p.m. on April 8, Respondent withdrew 2 milligrams of Dilaudid for Patient LL. At 4:02 p.m., Respondent wasted 1 milligram of Dilaudid for Patient LL. Respondent documented in Patient LL's Medication Administration Record that she administered 1 milligram of Dilaudid to Patient LL at 4:05 p.m. Respondent failed, however, to document the administration of the Dilaudid at 4:05 p.m. in Patient LL's Progress Record. Respondent also failed to assess Patient LL's pain before withdrawing the Dilaudid at 4:02 p.m. Finally, Respondent failed to assess the effect of the Dilaudid administered to Patient LL at 4:05 p.m.

17. At 5:32 p.m. on April 8, 2011, another nurse documented the following in Patient LL's Progress Record: "Report given to RN M. Salazar".

18. At 6:13 p.m. on April 8, 2011, Respondent withdrew 2 milligrams of Dilaudid for Patient LL. At 6:13 p.m., Respondent wasted 1 milligram of Dilaudid for Patient LL. At 6:30 p.m. on April 8, Respondent administered 1 milligram of Dilaudid to Patient LL. Respondent failed to assess Patient LL's pain before withdrawing the Dilaudid at 6:13 p.m.

**Patient MM**

19. On or about April 27, 2011, Respondent provided care for Patient MM. At 2:57 p.m. on April 27, Respondent withdrew 2 milligrams of Dilaudid for Patient MM. At 3:15 p.m. on April 27, Respondent administered 2 milligrams of Dilaudid to Patient MM. Respondent failed to assess Patient MM's pain before withdrawing the Dilaudid at 2:57 p.m.

20. At 6:28 p.m. on April 27, 2011, Respondent withdrew 2 milligrams of Dilaudid for Patient MM. At 6:35 p.m. on April 27, Respondent administered 2 milligrams of Dilaudid to Patient MM. Respondent failed to assess Patient MM's pain before withdrawing the Dilaudid at 6:28 p.m.

**Patient WT**

21. On or about April 19, 2011, at approximately 3:00 p.m., a physician ordered 4 milligrams of Dilaudid for Patient WT. Respondent signed the order for Dilaudid on April 19 at approximately 3:10 p.m.

22. On or about April 19, 2011, Respondent provided care for Patient WT. At 12:24 p.m. on April 19, Respondent withdrew 4 milligrams of Dilaudid for Patient WT without a physician's order. At 12:45 p.m. on April 19, Respondent administered 4 milligrams of Dilaudid to Patient WT without a physician's order. Respondent failed to assess Patient WT's pain before withdrawing the Dilaudid at 12:24 p.m.

23. At 3:57 p.m. on April 19, 2011, Respondent withdrew 4 milligrams of Dilaudid for Patient WT. At 4:00 p.m. on April 19, Respondent administered 4 milligrams of Dilaudid to Patient WT. Respondent failed to assess Patient WT's pain before withdrawing the Dilaudid at 3:57 p.m.

24. At 6:31 p.m. on April 19, 2011, Respondent withdrew 4 milligrams of Dilaudid for Patient WT. At 7:02 p.m. on April 19, Respondent administered 4 milligrams of Dilaudid to Patient WT. Respondent failed to assess Patient WT's pain before withdrawing the Dilaudid at 6:31 p.m.

**Patient JP**

25. On or about April 22, 2011, at approximately 3:50 p.m., a physician ordered 1 milligram of Dilaudid for Patient JP. The order indicated the following: "May repeat x1".

26. On or about April 22, 2011, Respondent provided care for Patient JP. At 3:50 p.m. on April 22, Respondent withdrew 2 milligrams of Dilaudid for Patient JP. At 3:51 p.m., Respondent wasted 1 milligram of Dilaudid for Patient JP. At 4:25 p.m. on April 22, Respondent administered 1 milligram of Dilaudid to Patient JP. Respondent failed to assess Patient JP's pain before withdrawing the Dilaudid at 3:50 p.m.

27. On or about April 22, 2011, at approximately 4:35 p.m., another nurse, RP, withdrew 2 milligrams of Dilaudid for Patient JP. At 4:35 p.m., RP wasted 1 milligram of Dilaudid for Patient JP. At 4:50 p.m. on April 22, RP administered 1 milligram of Dilaudid to Patient JP.

28. On or about April 22, 2011, at approximately 5:15 p.m., a nurse practitioner ordered 1 milligram of Dilaudid for Patient JP.

29. At 5:05 p.m. on April 22, 2011, Respondent withdrew 2 milligrams of Dilaudid for Patient JP without a valid order. At 5:06 p.m., Respondent wasted 1 milligram of Dilaudid for

1 Patient JP. At 5:45 p.m. on April 22, Respondent administered 1 milligram of Dilaudid to Patient  
2 JP. Respondent failed to assess Patient JP's pain before withdrawing the Dilaudid at 5:05 p.m.

### 4 **FIRST CAUSE FOR DISCIPLINE**

#### 5 **(Incompetence)**

6 30. Respondent is subject to disciplinary action under section 2761, subdivision (a)(1) of  
7 the Code and California Code of Regulations, title 16, sections 1443 and 1443.5 for incompetence  
8 in that Respondent (1) withdrew Dilaudid for Patient LL and administered Dilaudid to Patient LL  
9 before receiving report on Patient LL; (2) failed to document the administration of Dilaudid to  
10 Patient LL in Patient LL's Progress Record; (3) failed to assess the effect of Dilaudid  
11 administered to Patient LL; (4) failed to assess several patients' pain before withdrawing Dilaudid  
12 for those patients; (5) withdrew Dilaudid for Patient WT and administered Dilaudid to Patient  
13 WT without a physician's order; and (6) withdrew Dilaudid for Patient JP without a valid order.  
14 The circumstances of Respondent's conduct are set forth above in Paragraphs 16 through 29.

### 15 **SECOND CAUSE FOR DISCIPLINE**

#### 16 **(Gross Negligence)**

17 31. Respondent is subject to disciplinary action under section 2761, subdivision (a)(1) of  
18 the Code and California Code of Regulations, title 16, section 1442 for gross negligence in that  
19 Respondent (1) withdrew Dilaudid for Patient LL and administered Dilaudid to Patient LL before  
20 receiving report on Patient LL; (2) failed to document the administration of Dilaudid to Patient  
21 LL in Patient LL's Progress Record; (3) failed to assess the effect of Dilaudid administered to  
22 Patient LL; (4) failed to assess several patients' pain before withdrawing Dilaudid for those  
23 patients; (5) withdrew Dilaudid for Patient WT and administered Dilaudid to Patient WT without  
24 a physician's order; (6) withdrew Dilaudid for Patient JP without a valid order; and  
25 (7) placed two empty vials of Dilaudid in her pocket. The circumstances of Respondent's  
26 conduct are set forth above in Paragraphs 13 through 29.

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1 **THIRD CAUSE FOR DISCIPLINE**

2 **(Illegal Possession of a Controlled Substance and Dangerous Drug)**

3 32. Respondent is subject to disciplinary action under section 2762, subdivision (a) of the  
4 Code in that Respondent (1) placed two empty vials of Dilaudid in her pocket; (2) withdrew  
5 Dilaudid for Patient WT without a physician's order; and (3) withdrew Dilaudid for Patient JP  
6 without a valid order. The circumstances of Respondent's conduct are set forth above in  
7 Paragraphs 13 through 15, 21, 22, 28, and 29.

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9 **DISCIPLINARY CONSIDERATIONS**

10 33. On or about October 5, 2009, while employed as a registered nurse at Alta Bates  
11 Summit Medical Center in Berkeley, California, Respondent was issued a Notice of Disciplinary  
12 Action. Under "Reason for Disciplinary Action", the Notice states the following: "You are being  
13 disciplined for job performance and for failing to follow policy for medication administration:  
14 You have been noted to: Operate outside of policy and procedure: Medicate patients without  
15 documenting assessment, delivery of drug and reassessment of effectiveness of intervention."  
16 Under "Plan of Corrective Action", the Notice states in pertinent part: "[Respondent] will  
17 properly administer and charge medications according to policy." Respondent signed the Notice  
18 on October 5, 2009.

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1 **PRAYER**

2 WHEREFORE, Complainant requests that a hearing be held on the matters herein alleged,  
3 and that following the hearing, the Board of Registered Nursing issue a decision:

4 1. Revoking or suspending Registered Nurse License Number 470460 issued to Monica  
5 Louise Salazar;

6 2. Ordering Monica Louise Salazar to pay the Board of Registered Nursing the  
7 reasonable costs of the investigation and enforcement of this case pursuant to Business and  
8 Professions Code section 125.3;

9 3. Taking such other and further action as deemed necessary and proper.  
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11 DATED: APRIL 17, 2013

12 *for* *Stacy Bern*  
13 LOUISE R. BAILEY, M.ED., RN  
14 Executive Officer  
15 Board of Registered Nursing  
16 Department of Consumer Affairs  
17 State of California  
18 Complainant  
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